EMS PROVIDER
REPORT OF EXPENDITURES FY 04
(A report is needed for each provider)

COUNTY of LICENSURE: _____

Counties of Operation: _____

_____

Name of EMS Provider: _____

Name of EMS Administrator (Print): _____

Re: Utilization of Funds Received from the EMS Trauma Care System Account

Total Amount of Allocation this Provider Received: $_____

Purchases/expenditures during period **December 1, 2003 - August 1, 2004**:
RECEIPTS ARE REQUIRED

Supplies: Item: _____ Cost: $_____
Item: _____ Cost: $_____
Item: _____ Cost: $_____
Item: _____ Cost: $_____

Education & Training: Course: _____
Persons Trained: _____ Date:_____
Cost: $_____

Equipment: Type: _____ Cost: $_____
Type: _____ Cost: $_____
Type: _____ Cost: $_____

Vehicles: Type: _____ Cost: $_____
Type: _____ Cost: $_____

Communications Equipment:
Type: _____ Cost: $_____
Type: _____ Cost: $_____

Other Operational Expenditures: _____
_____
_____

Anticipated Expenditures through August 31, 2004, if any: _____

Total Cost: $_____

Anticipated Expenditures through August 31, 2005, (Not required if entire contract amount is expended by August 31, 2004): _____

Total Cost: $_____

*Please prioritize and list anticipated needs for FY 2005 (9/1/04 - 8/31/05): _____
_____

*Please prioritize and list anticipated long-term system development needs: _____
_____

Name of person completing report (Print):_____

Title:_____ Phone: _____

RAC/County Authorized Signature: _____Title:_____

Name (Print): _____ Date:_____

*Please attach additional page if necessary.